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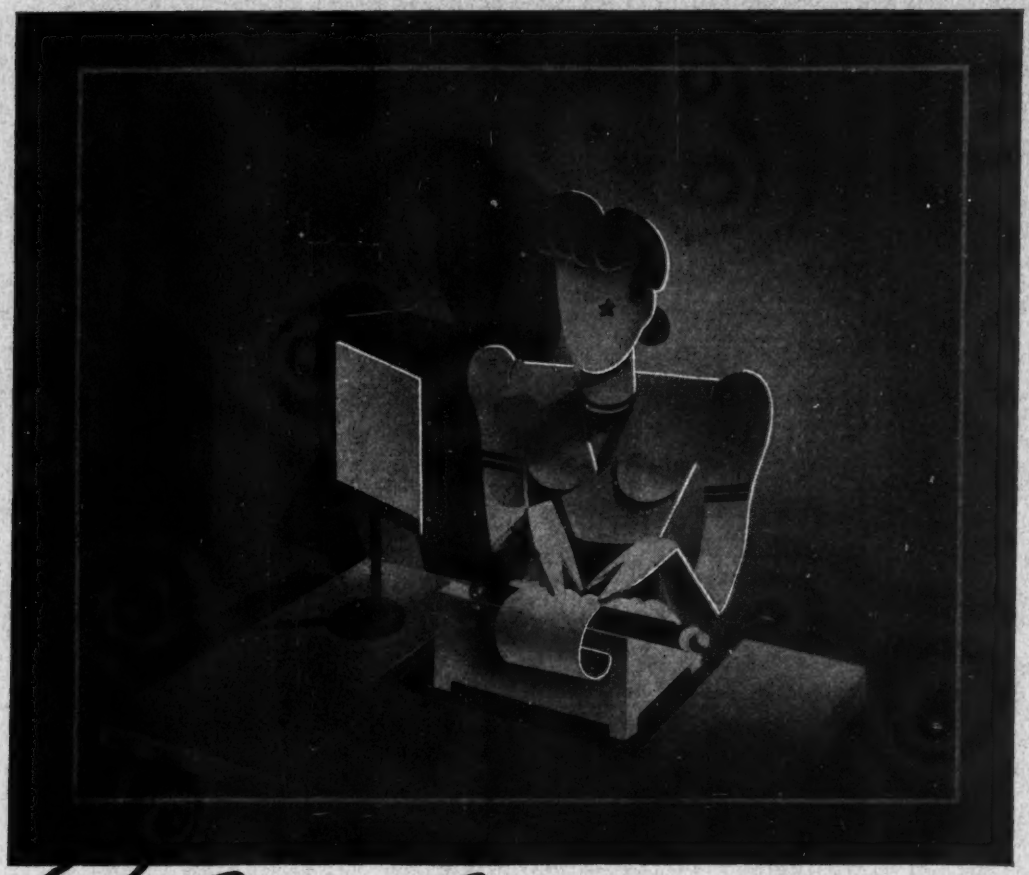

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GASTRIC AND DUODENAL SURGERY

RALPH A. GOWDY, M.D.
Miami Beach

This paper only briefly covers this subject in order that lantern slides may be shown which I hope will be of more interest to most of you than anything I might say.

One needs offer no apology for harping on gastric lesions since cancer of the stomach takes the lives of nearly 40,000 people each year in this country. Dr. Margaret Warwick[1], at the Minnesota University, held autopsies on 176 people who died from stomach cancer. She found that in 23 per cent of these cases the cancer had not extended beyond the walls of the stomach at the time of death. From her findings it is evident that a large percentage of these patients could have been cured by early surgery. At present surgical removal is the only known cure for gastric carcinoma and yet comparatively few receive surgical treatment. Most surgeons are willing to concede that duodenal ulcers should be treated medically unless perforation, obstruction or repeated hemorrhages have occurred.

Having decided that a duodenal ulcer falls into the small group which requires surgical treatment, the type of operation giving the best results is still much debated. Gastric resection is gaining ground for all types of peptic ulcer where operation is indicated. In perforated duodenal ulcer many surgeons still feel that it is best to close the ulcer and proceed no further. This may be proper when many hours have elapsed between perforation and operation or if the patient is in severe shock, but when the patient is in fairly good condition many feel it is not the best procedure.[2] Frequently these patients will not be well until a second operation is performed. On many occasions we do a pyloroplasty in the presence of perforation or even a gastric resection with no apparent operative shock, yet we do not believe gastric resection in the presence of perforated duodenal ulcer is usually the best operation. There are some cases of perforated duodenal ulcers in which gastro-enterostomy seems to be the only operation that can be used safely, but it should be used only when other operations are contraindicated.

CASE I, PLATE I

Perforated duodenal ulcer at head of pancreas causing obstruction. Age 38.

CASE I, PLATE II

Showing stomach one year after Billroth II type of resection. Patient well.

Read before the Sixty-sixth Annual Meeting of the Florida Medical Association, held at Daytona Beach, May 1, 2 and 3, 1939.

CASE I, PLATE III

Showing stomach seven years after Billroth II type of resection. Patient well.

In dealing with chronic duodenal ulcer producing obstruction the operative procedure depends on conditions found at operation. If the obstruction is at the pyloric sphincter a pyloroplasty is the most desirable, while if the ulcer is quite far past the pyloric sphincter and perhaps adherent to head of pancreas a Billroth II would likely be best. In either location of ulcer if the patient is old and his condition not the best, a gastro-enterostomy would be the operation of choice.

In the hemorrhaging type of duodenal ulcer which requires surgical intervention, a pyloroplasty and removal or suturing of ulcer is usually the best operation. Finsterer[3], however, does gastric resection in these cases. It is seldom necessary to operate during a severe hemorrhage.

In taking up gastric lesions one is confronted with a very different problem than when treating duodenal lesions. In general, we can say that duodenal lesions are medical problems and that only the complications require surgery, while gastric lesions are surgical problems. Of course, there are a few gastric lesions that will heal under medical treatment and remain healed. Because of these few medical cures a great many other gastric lesions are treated medically until the chance for a surgical cure has passed. The death rate from surgical removal of lesions that might heal under medical treatment would be very small but the death rate from malignant gastric lesions treated medically is appallingly large. It is well known that the symptoms caused by early gastric cancer will subside under medical management and gastric analysis may show normal hydrochloric acid. The

CASE II, PLATE I

Deep ulcer high on lesser curvature, severe pain and many gastric hemorrhages. Age 65.

CASE II, PLATE II

Showing stomach 2 years after Billroth I type of resection. Patient well.

Case II, Plate III

Showing stomach 8 years after extensive resection by Billroth I type. Patient well.

Case III, Plate II

Showing stomach 2½ years after taking down of gastrojejunostomy and doing a Billroth I type of resection. Patient well.

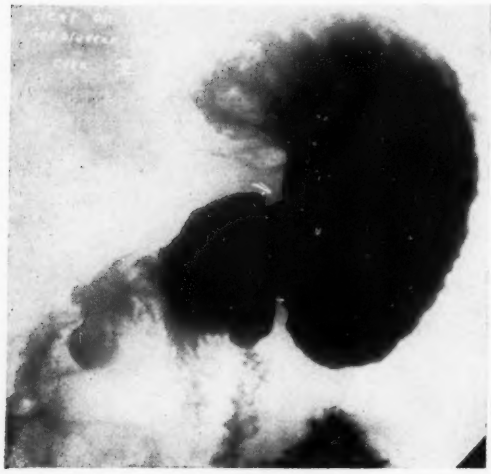
patient may gain weight and the lesions may even heal by x-ray. During this period the only chance for a permanent cure by surgery may be lost.

Let me repeat that the only known cure for gastric carcinoma is surgery and in most cases surgery must take place while the lesion is still apparently benign. If a patient states that no digestive disturbance was noticed before the age of forty and by roentgenogram a gastric lesion is found, it should be considered a surgical problem. Benign gastric lesions of all kinds usually start before the age of forty.

Case III, Plate I

Showing ulcer in stoma of gastrojejunostomy done for perforated duodenal ulcer nine years before. Woman aged 36, very much underweight.

Most operations on the stomach fall into the types of operations known as Billroth I or Billroth II. Each of these types has many modifications some of which we will discuss. The Billroth I operation is especially effective in those people in whom sufficient gastric tissue can be removed and the proximal part of the stomach united to the duodenum without tension. This leaves the digestive apparatus in its physiological arrangement since the food still passes down the duodenum in its normal course. The Billroth I operation is not followed by jejunal ulcer as may happen occasionally with other gastric operations in which the stomach empties directly into the jejunum. The sleeve type of stomach resection is useful in removing a large tumor from the fundus. If the pyloric end of stomach is obstructed with a lesion that cannot be removed a gastroenterostomy will give relief and possibly at a later date the obstructive lesion can be removed.

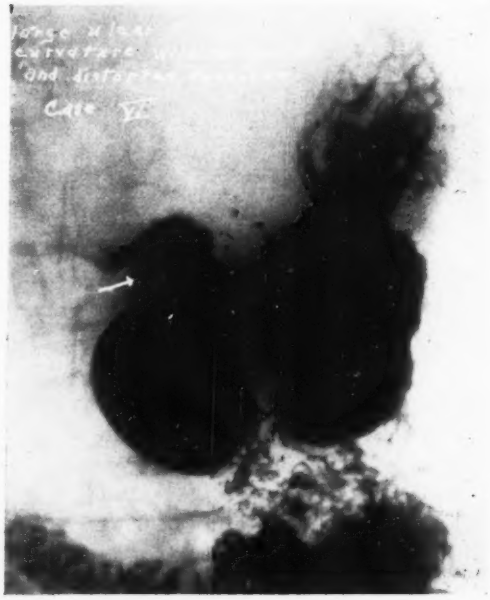


CASE V, PLATE I

Showing stomach 15 years after gastrojejunostomy had been done for perforated duodenal ulcer and 9 years after gastrojejunostomy had been taken down for stomal ulcer and a pyloroplasty done. Large ulcer on lesser curvature with gallbladder firmly adherent to ulcer.

CASE V, PLATE II

Showing stomach 1½ years after extensive resection by Billroth I type of resection. Patient well. Age 70.



CASE VI, PLATE I

Showing stomach with large ulcer prepyloric on lesser curvature with great deformity to duodenum, ulcer found 15 years before by x-ray; would not consent to surgery until obstruction developed. Age 65.

By far, the greater number of stomach operations fall into the type of operation known as Billroth II. There are many modifications of this operation but in all of them the distal part of the stomach is closed or removed and the proximal part is attached to the jejunum so that food passes from stomach to jejunum without passing through the duodenum. In most cases the original Billroth II operation seems better than any of the modifications. A majority of surgeons, however, employ the Polya modification, or some modification of a Polya. When the original Billroth II does not seem desirable I like the Hofmeister modification of a retrocolic Polya as it leaves a smaller opening through which the food must pass to the jejunum somewhat similar to the Billroth II.

In presenting this paper it is my desire to again bring up for discussion stomach and duodenal lesions. Until we can lower the death rate from stomach cancer we must continue to harp on gastric lesions. It is our duty to impress on the public that gastric lesions are serious unless proved otherwise, especially so in people over forty years old. Every person past this age having digestive trouble should have gastro-intestinal roentgenograms. This would enable us to locate many lesions early when surgical removal might give a permanent cure. In doing gastric and duodenal surgery I use only absorbable suture material. Stomach or intestinal clamps are not placed on the tissue to be left. It does not seem reasonable that a clamp can be used

Case VI, Plate II

Showing stomach 2 months after extensive resection, Billroth II type. Patient well.

Case VII, Plate I

Showing large carcinoma in fundus; no metastasis could be found. Age 60.

on the stomach or intestine for thirty minutes without doing permanent damage. Blood transfusions, Wangensteen drainage, intravenous normal saline and dextrose are all used following this type of surgery.

All of the lantern slides to be shown are from private cases most of which have been followed for several years. By these slides I will try to demonstrate different types of gastric and duodenal operations and show results following these operations.

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541 Lincoln Road.

DISCUSSION

Dr. Walter C. Jones, Miami:

Doctor Gowdy has presented a very interesting paper to us. However, I think we have taken on our hands this morning a subject which is so great that it is impossible for us to get more than a brief summary from it.

In the first place the discussion of this paper of Doctor Gowdy necessarily must divide itself into two distinct divisions as to the indications for handling duodenal and gastric lesions. The medical and surgical management of these cases are so entirely different that

Case VII, Plate II

Showing stomach 6 months after extensive resection of fundus. No recurrence in stomach. Metastasis in liver. Free from gastric pain after operation.

discussing one subject without differentiating it would be impractical. Also in discussing duodenal ulcers we must consider them in both the acute stage and the chronic stage.

We have had friendly discussions with medical men on this operable question and I think we now agree on a more conservative management of these duodenal lesions unless we have rather definite indications for surgery in the duodenum. This is still a very debatable subject, however, from the surgical standpoint.

In ruptured peptic ulcers, whether to do the simplest type of technique or simple closure with omental transplantation or whether to do more radical surgery is to be decided in the individual case.

For about ten years I have been getting a little more radical in my treatment of acute ruptured ulcers, and I think advantageously so. My first experience with them was some ten years ago. At that time I had a case, a woman with acute ruptured ulcer which was overlooked for some twenty-four hours. I operated and found an ulcer on the anterior wall, marked induration as you would expect with plastic exudate in and about the area. I attempted to do what seemed most easy—to close it and put some omentum over it, but my attempt was futile. I felt that it was impossible for me to accomplish anything in that case, so I proceeded to do a resection of that ulcer using the Judd type of resection. Much to my surprise the patient ran an uneventful course. Naturally such procedures in surgery make us stop and think. We have been doing this on practically all of our ruptured ulcers for the last ten years.

This question will take considerable time if we go into details, but I think we have been entirely too conservative in the management of ruptured peptic ulcers. I think our ruptured peptic ulcer patients die not from surgery but because we did not accomplish a closure. They die, as you look back over your cases, five or six days after operation.

In the chronic type of duodenal ulcer, I think, obstruction of course is the chief indication for surgery. In that type of case the question of what is best to do is an individual problem for study in each case.

I do want to stress one thing that has not been brought out in the obstructive type of ulcers. These patients must not be operated upon until they have been thoroughly prepared. Thorough preparation is not a twenty-four hour proposition. It takes weeks to get this stomach back to normal or to the proper state for any surgical procedure you may anticipate. I think if we don't properly prepare these chronic cases we will be defeated before we begin our surgery.

The type of operation that we will do on these particular cases is something that we cannot go into extensively now. I think Doctor Gowdy's discussion of it has been very clear. I am in favor of the Finney type of operation for mobile cases. And I think that the Horsley type is quite satisfactory in some cases that are not quite so mobile. I don't feel that the Judd type has been entirely satisfactory.

I am beginning to believe that we are going back to the gastro-enterostomy which was in vogue some twelve to fifteen years ago, especially in these obstructive cases.

I feel that the gastroscope is going to be a great deal of help in some of these gastric cases. We will not have to open up the abdomen to differentiate between inflammatory and malignant cases. But where there is any question, gastric surgery is mandatory. I think resection in these cases of the lesion itself and necessary portion of the stomach is the thing we must do. The question of cancer in a gastric lesion is one we must not forget.

Dr. Ralph A. Gowdy, (Concluding):

In regard to the gastroscope I would say that it is very important in helping us to make a diagnosis of certain stomach conditions especially gastritis, and no doubt will be used extensively from now on. To make a positive diagnosis between chronic benign gastric ulcer and carcinomatous ulcer during the early stages of the latter is impossible by gastroscope. It can only be done by microscopic examination of the tissue after removal by surgery. If we delay surgery in gastric lesions until we can be sure they are malignant by gastroscope or x-ray the chances for cure by surgery will be very small. The only time the probability of a permanent cure for gastric carcinoma is great is when it still is apparently a benign lesion. For this reason I advocate surgery on gastric lesions which do not heal and remain well by x-ray after a short period of medical treatment.

I recently saw a review by Dr. George B. Eusterman, of an article written by Dr. Rudolph Schindler on Gastroscopy. Doctor Eusterman says: "Schindler's enthusiasm for this procedure is understandable and pardonable. On the other hand, he frankly informs us that ulcers of the duodenum and pylorus cannot be seen gastroscopically and that the lesser curvature of the antrum often remains hidden from view. Yet it is at these very sites that the vast majority of gross, chronic, benign and malignant lesions of the upper digestive tract, so readily demonstrated by the experienced roentgenologist, are located. The reviewer is also of the opinion that differential diagnosis between a chronic benign gastric ulcer and a carcinomatous ulcer (not ulcerating carcinoma) especially in the earlier stages of the latter, is impossible gastroscopically in many instances."

Gastroenterostomy seems to be especially desirable in obstructive duodenal ulcer of long duration. In hypertrophic pyloric obstruction in babies the Rammstedt operation gives almost instant relief. Last Wednesday I did a Rammstedt operation on a baby. The baby left the hospital on Sunday apparently well.

I agree with Doctor Jones that the complications of duodenal ulcer require surgery and in most cases should be treated medically until obtruction, perforation or repeated hemorrhages have occurred. I have also encountered some difficulty with the Judd pyloroplasty in getting the stomach to empty as quickly as it will with a Billroth I resection or some other type of gastric operation.

I am sorry time did not permit showing all of the slides.

THE IMPORTANCE OF CASE RECORDS RELATIVE TO THE CANCER PROBLEM

R. L. ELLISTON, M. D.
Ft. Lauderdale

The etiology of cancer continues to challenge scientific endeavor. However, when one reviews the observations made, and the results of animal experimentation of the last few years, he cannot help but be impressed with the progress being achieved by those devoting their time to this important subject. It is probably well that we pause occasionally and ask ourselves if we, as physicians, are doing all in our power to carry on our part in regard to this major problem.

In 1932 McFarland and Meade published a paper on the genetic origin of tumors supported by their simultaneous and symmetri-

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cal occurrence in homologous twins. They reported a number of cases showing congenital defects, a variety of systemic diseases, and neoplasms. Their studies seemed to indicate that if a tumor develops in an identical twin, in a given organ at a given time, the same type of tumor will develop in the other twin in the corresponding organ at, or near the same time.

Obviously in a study of this kind it is necessary that one deal with true identical twins. Since only one-fourth of all twins are identical, and since but one identical twin birth occurs in 360 births, material of a pathologic nature in this group is scarce. By studying the character of the placenta one can say definitely whether the case is, or is not, one of identical twins. In studying a large number of twins Greulich found 25.4 per cent to be identical. Guttmacher, in his examination of placentas alone, found 25.7 per cent to be identical.

Homologous twins are considered to be the product of one ovum and one spermatozoon, which in splitting in very early embryonic life, give to each new individual half, or nearly half, of the chromosome and gene structure. If this is so, it is logical to suppose that each of the new beings will be subjected to a considerable degree, to the same inheritance factors. Some cases have been reported which give strong evidence in support of this theory. In 1936 Mumford and Linder reported an instance of carcinoma of the breast in homologous twins. These tumors developed within a few months of each other, in the left breast of each, when they had reached the age of 91. Benedict reported a case of retinoblastoma in the corresponding eye of each member of homologous twins at the age of four years. Last year Phillips of the Mayo Foundation, reported a case of bilateral mammary carcinoma in identical twins. In this case carcinoma developed in the right breast of the first twin three years before it occurred in the same breast of the second twin.

In the study of certain families the incidence of cancer is found to be relatively high. One of the most outstanding cancer families in this country, was first reported by Warthin in 1913, and again in 1925, and by Hauser and Weller in 1936.

The paternal founder of this family died about 1856 at the age of sixty, with what was thought to be cancer of the stomach or intestines. In an analysis of the descendants of this parent, fifty-four deceased, who attained the minimum cancer age of twenty-five years, 35, or 64.81 per cent, developed cancer. Of the 305 descendants, 174 attained the age of twenty-five years, and of this number, 41 developed cancer, an incidence of 23.6 per cent. If the 25 members of the two branches of the family in which malignant disease has never appeared, and who have reached the cancer age are excluded, the incidence of cancer is 27.5 per cent.

Hauser and Weller have pointed out that an inspection of the entire family record gives the impression that there is a decreasing incidence of cancer in the younger generations, which seemed to them to be more apparent than real, and that not until the full effect of age becomes known, with respect to the third and fourth generations, can the question of a decreasing incidence of cancer be determined. They contended that if there was a diminishing incidence, it would argue for and not against an intrinsic predisposition to malignancy, as evidenced by the fact that cancerous members of the third generation have to a marked degree, failed to leave issue, and that of the entire family group, 15, or 36.58 per cent of the 41 cancerous individuals have died without leaving issue.

It is also interesting to note in this family the tendency of marked organ susceptibility, as shown by the fact that of the 43 primary cancers in the 41 individuals, 26 have occurred in the gastro-intestinal tract, and 15 in the endometrium, which is in contrast to only one in the breast and one on the skin of the nose.

In a recent issue of *Surgery, Gynecology and Obstetrics*, Holmar called attention to the possibilities which lay open to us in a careful study of the genetics in relation to cancer. He cited six so-called cancer families, and suggested that it would be worth while to have a central library where cases of cancer with definite genetic aspects could be collected for further study. In the next issue of the same journal, Lockhart-Mummery wrote a paper in which he emphasized the fact that the profession had not paid sufficient attention to the problem of genetics in cancer.

The biological evidence in support of the

hereditary theory of cancer development, contributed by Maud Slye of the University of Chicago, is most interesting. By 1913 she had accumulated, in four years, a stock of about 5,000 mice of known ancestry. It was with this stock of mice, in which neoplasms had begun to appear spontaneously, that she started her now famous studies on the relationship of heredity to spontaneous cancer. During the course of her extensive breeding experiments, she has isolated strains of mice, which regardless of environmental influences, have never had cancer. In contrast to this she has developed strains which show a 100 per cent incidence of cancer. She has also isolated strains which show a marked tendency to the development of special types of tumors and still other strains which show a 100 per cent organ susceptibility to tumors.

According to a 1937 report Maud Slye has performed necropsy on 140,000 mice, in which she has observed 100,000 cancers. She contends that malignancy is transmitted as a localized recessive character, and that each type of malignancy is a unit character capable of suppression by a dominant. For example, she believes that there is one unit recessive character for carcinoma, one for sarcoma and one for leukemia, and that the location factor which determines where malignancy shall occur is transmitted as a recessive character capable of supression by a dominant. Thus there is one unit recessive character for each location of malignancy, such as the breast, lungs, abdominal wall, and so forth, and the tendency to carcinoma, sarcoma or leukemia differs in only one gene from the tendency to noncarcinoma, nonsarcoma or nonleukemia. Hence the genetic pattern for a malignant tumor and its location each requires a unit recessive, one for the malignancy itself, and one for its location.

According to Maud Slye's investigations, susceptibility and nonsusceptibility to spontaneous neoplasms in mice depend absolutely upon genetic factors. At present we do not possess sufficient evidence to make a similar claim in regard to the development of neoplasms in man. However, since man and mouse are governed by the same biologic laws, it seems logical to assume that susceptibility and nonsusceptibility in the human race, do depend on such factors.

Many investigators have studied the mechanism of tissue repair in wound healing. Notable among these research workers is Carrel. He was able to show by his experiments, that a wound free from debris of tissue and blood clots, and absolutely protected from outside irritation, does not heal. He believes that every mild irritant brings about the invasion of leukocytes, which in secreting so-called "trephones" induce cicatrization.

Murphy was able to show that after an animal had been exposed to x-rays, lymphocytes divide in its serum more readily than in that of the untreated animal. Carrel attributes this effect to the destruction or stimulation by x-rays of lymphocytes and the liberation of "trephones" in the plasma.

In the laboratories of the Institutum Divi Thomae of Cincinnati, Loofbourow, Dwyer, Sperti and others have isolated metabolic stimulating factors from cells. In their experiments they have shown that injured cells secrete substances which stimulate growth, respiration and the utilization of sugars. Not only have they shown that there are proliferation-promoting and inhibiting substances in tissues and in cell cultures, but that proliferation-promoting substances are elaborated by injured living cells as a definite response to injury. The most potent preparations of the proliferation-promoting substances were produced by prolonged injury to cells before death took place. They therefore believe that these substances are elaborated by living cells during injury. These substances are effective in such small quantities as to suggest that their action is hormone-like. They believe that in the case of benign and malignant tumors it is reasonable to postulate that the fundamental mechanism involved is the collection in abnormal concentration of metabolic stimulating factors produced by cells as a result of irritation or injury of long standing.

Recently Bittner and his co-workers of the Jackson Memorial Laboratory, Bar Harbor, Maine, have performed some interesting feeding experiments on mice born to females showing a high breast tumor incidence. These young mice were removed from their mother as soon as recorded, and fostered by females of a line showing a low breast tumor incidence. Of these fostered females and their

progeny 23.1 per cent developed breast tumors, while the incidence of breast tumors among the control mice was 83.2 per cent. Other series gave similar results. They conclude that their experiments would tend to indicate that some influence is transmitted through the mother's milk, which is of prime importance in determining the incidence of breast tumors. The incidence of breast tumors may be significantly decreased by fostering females of a high breast tumor stock by low tumor stock mothers.

In setting forth these observations and this experimental evidence it has not been my purpose to uphold any particular theory as to the cause of malignancy, but due to such interesting and encouraging findings lending hope to the solution of this problem, I wish to encourage a more extensive, united effort on the part of the medical profession in gathering and recording data on those individuals suffering and dying of this disease. It is especially urged that the forms used in recording such data be of a uniform type to make this work more simple, efficient and valuable when a study of these records is undertaken.

In order that we may more nearly parallel important findings in animal experimentation, it is proposed more space be given pertinent questions than is now found on most of our existing forms. Space for an adequate family history asking for the names of the individuals with their address, or place of death, and cause of death, would seem necessary. A question asking for previous infection, irritation or injury at the site of the lesion, should appear on such a form. It would also seem desirable that consideration be given the character of the early nourishment of the individual. By all means these forms should be uniform.

I realize some of the difficulties attending an effort to unify our record system. In the summary of the report of the Committee on Clinical Records of the American Hospital Association of 1937, in reference to a questionnaire sent to 231 widely distributed hospitals, the following was taken:

Twenty-seven per cent replied that they had found the record forms suggested by the previous committee useful; twenty-one per cent had not found them useful; and six per cent replied that they had not seen these forms. Seventeen per cent had adopted some of these forms; thirty-five per cent had not adopted any of these forms; and forty-six per cent did not make any reply to this question.

Such a discouraging report gives us a fair idea of the probable prevailing conditions of today. This should stimulate our efforts to correct this situation, which would appear most necessary. It is therefore proposed that a committee be appointed for the purpose of studying forms for obtaining records of cancer cases, and to obtain their adoption throughout the state; this committee to work with the committee on cancer control and the committee on clinical records of the American Hospital Association, and the American College of Surgeons.

It is further proposed that copies of such forms when adopted, be sent to each county medical society within the state and their cooperation solicited in this work, that they be encouraged to use these forms in making records of all cancer cases, both institutional and noninstitutional, such records to be properly filed at designated central stations.

Should such a unified system of obtaining data on malignant cases be adopted generally, much valuable information which is now being lost could be grouped in such a manner as to afford ideal conditions for study, thereby assisting in the solution of a problem, which has thus far remained unsolved.

814 Sweet Building

DISCUSSION

Dr. E. M. Hendricks, Ft. Lauderdale:

I want to thank Doctor Elliston for his timely appeal for a cancer registry.

When Maud Slye first propounded her theory and first published her work, hardly any man in the medical profession accepted her findings as facts. There was much critical discussion some even approaching ridicule. However, her work has now advanced to such a place that we can no longer disregard the results. She has shown that a mouse can be bred on demand which will die of cancer in any desired portion of the body. The proof of her hereditary theory of cancer is so clear cut that any other conclusion seems untenable. She has also found that she can breed cancer out of her mice in about three generations. This is of vital importance.

There has been little investigation of the hereditary factors of cancer as they are applied to humans. Here and there a family has been selected for intensive study but the data obtained have been too meagre to draw any definite conclusions. Maud Slye in her life has studied enough generations of mice which if applied to humans would carry us back almost to the Pharaohs. If we started now, our investigations would not be finished by us nor our grandchildren, but a start must

be made sometime as each delay projects still further the time of the final solution of this problem. If there is a definite hereditary factor for the production of cancer in the human beings, let us know it, and if there is a eugenic solution to the problem let us find it. If Maud Slye can breed cancer out of her mice in three generations, is it not probable that the same can be done with human beings? This would certainly be a remarkable piece of work.

In the first place we should attempt to obtain adequate case and family histories. The information obtained from several generations may be sufficient to enable us to correlate the findings of experimental animal breeding with the human problem and so show us a definite plan for the elimination of cancer. There will be a certain expense involved but the value of the information obtained will be far greater than the small amount of money entailed in the operation of a central registry. Cooperation of the entire medical profession is of course essential. This may be difficult to obtain; the gradual realization of the importance of the work will aid materially in getting this cooperation.

Maud Slye has written that she can breed out as well as breed in cancer. Our Florida registry will show whether this is possible with humans.

Dr. F. K. Herpel, West Palm Beach:

I appreciate the opportunity of discussing Doctor Elliston's paper. I think it is very timely.

I will not go into the difficulties of such a program, but I am sure you all realize that we will have to record our experiences in cancer clinics, establish something similar to the pathological library of Johns Hopkins University founded many years ago by Doctor Bloodgood.

Certainly it is very difficult to get follow-up records on patients examined. The same thing will apply to any attempt to get statistical records. Patients leave without adequate records being obtained.

In any customary group of 100 white females, about 13 of these will die of cancer under our present set-up. In a combination group of 100, ten will die of cancer. It is estimated that there are probably 500,000 people afflicted with cancer in the United States at any one time. Cancer has become the second cause of death. Also in 1936 it was established that we had 150,000 deaths as a result of carcinoma or malignant disease. Under the age of 55 cancer deaths are more frequent in women, whereas in ages over 55 they are more frequent in men. White women have a lower death rate than colored women, white men a higher death rate than colored men.

Many facts come out with regard to cancer which will require extremely careful records.

There has been a definite increase certainly in the incidence of cancer of the breast, also a fall in incidence of cancer of the cervix. We know the occurrence of cancer in the breast is more frequent in women who have not nursed children than in women who have nursed children. Cancer of the cervix is more frequent in women who have borne children and have torn cervices than in women who have never been pregnant.

What is the consequence of these findings in view of the lowering birth rate in this country? We are having more sterile marriages in this country and they are increasing with the decreasing birth rate. Naturally there are fewer women out of every 100 who nurse children, and fewer who suffer injury to the birth canal. None of this can be determined from our present statistics.

Dealing as I do with the treatment of malignant disease, I realize only too well the difficulty attendant upon securing adequate records. In addition to the comments by Doctor Hendricks, not infrequently we have cases in which it is not desirable to acquaint the patient with the true significance of his disease.

I think I must say that in a survey of the American College of Surgeons in 1933 and 1934, they did obtain definite case histories in 25,000 patients with breast cancer. Some lived five years after treatment with no recurrence of symptoms. I think if we all keep that fact in mind despite the fact that we are having 150,000 people die every year from cancer, we will realize that our efforts are worth while.

As Doctor Elliston has brought to our attention, I think we all should bear in mind the necessity for adequate records in attempting to check where we are going in this problem of the treatment of cancer.

Dr. L. L. Whiddon, Ft. Pierce:

The essayist well said the cause of cancer is still baffling organized medicine and the world. It is very embarrassing to me to continue to come up and say that sugar is the cause of cancer when I base my statement only upon empirical observations. However, the man who first decided and said what was the cause of infection in motherhood after childbirth had to depend only upon such observations.

Lord Kennenger, of London, Professor of Medicine, not only said that sugar caused cancer, but he showed by graphs that when sugar consumption came up cancer also came up from 1849 to 1928 which was the end of the graph. In 1914 when sugar was taken away from the civil population of England, sugar consumption went down and the incidence of cancer went right down with it. It stayed there until 1919 when sugar was again given to the people. When sugar consumption came up, cancer also came up. When we increase our sugar consumption, we are sure to get cancer in the same ratio.

About three years ago I was in New York and accidentally met Doctor Gratz, Professor at Columbia University. He took me out to lunch and he saw me put saccharine in my tea instead of sugar. "Diabetes, Doctor?" he asked. I said, "No, but I think sugar is the worst food in the world." He said, "Doctor, you are right." I said that I thought it was even the cause of cancer. He said I was exactly right. I said I had told the profession in Florida that it was the cause of cancer and they laughed at me. He said to let them laugh, that they would eventually come to the same conclusion.

He said Doctor Deeks, the president of the American Fruit Company, "put him wise" several years ago, and immediately he checked 100 cases of cancer at the Mt. Sinai hospital and that day sugar and white bread went out of his home. He said he and Doctor Deeks planned to write a book on sugar as the cause of cancer but Doctor Deeks died and he had not had time. Doctor Deeks was president of the American Fruit Company with $40,000,000 invested in sugar, and at the same time he was going to help Doctor Gratz write a book condemning sugar!

Granulated sugar is granulated poison. This statement was made by Doctor Banting of Canada. I could stand here and talk all afternoon upon laboratory reports of sugar investigations but there is no time. We caused tumors in rats by feeding them sugar. I don't doubt that Maud Slye bred rats with cancer, but she did not breed cancer into rats. She just bred the susceptibility in them. Sugar does not cause 100 per cent of cancer, but it does cause a lot of people to have cancer who would not have it if they did not eat sugar.

Sugar causes many other conditions. I am willing to say it causes almost all upper respitory affections.

I went off sugar seven years ago, and I want to tell you I had influenza six times in my life and common colds five to ten times a year, but in the last seven years, practicing complete abstinence from sweets of all kinds in the way of foods, I have not had one bad cold in the entire seven years!

WATER AND SALT METABOLISM

Karl Hanson, M.D.
Jacksonville

It is hard to think of a phase of human physiology which more vitally concerns all phases of medicine than does fluid balance. It particularly concerns the surgeon and the internist. What is the practical significance of fluid balance? It simply means the balance that must take place between the total intake of water plus water liberated by metabolism and the output of water resulting in the maintenance of a fairly constant level of the body water content.

Gamble[1] states that the cell itself needs no water because it makes its own in excess in its metabolism, thus pointing out that water balance is an extracellular problem. He states that about 5 per cent of the body weight is made up of blood, 15 per cent of extracellular fluid and 50 per cent of intracellular fluid. The margin of safety for variation of fluid intake and fluid loss is in the interstitial fluid which keeps the plasma fairly constant in volume. This remains true until practically all of the interstitial fluids have been lost. He also pointed out that the osmotic pressure of extracellular fluids is due almost entirely to the sodium, chloride and bicarbonate ions and that the volume of the extracellular fluids is dependent on the amount of sodium ions in it.

Water is obtained from two principal sources: (1) fluids drunk, 800-2000 cc. and (2) food consumed which includes water derived from the food itself and the water of oxidation. This amounts to about 1000-1500 cc. daily. Water is excreted through three main channels: (1) water of the urine, 1000-1500 cc. per day, (2) water of the stool, 150 cc. per day, and (3) water of vaporization, 1000-1500 cc. per day. This includes water lost by the skin and lungs.

In considering fluids available from food, it is well to remember that in the case of many acutely ill patients and many surgical patients food may for some reason be withheld in which case the water available from this source comes from tissue oxidation only, and amounts to about 500 cc. daily. For practical purposes, as suggested by Coller[2], the latter may be disregarded. The fluid output in postoperative patients and in certain acute illnesses should allow for a 1500 cc. output by urine a day because it is by this means that waste materials in solution are removed from the blood. A normal kidney functioning at its maximum excretory power can remove the waste materials necessary in about 500 cc. of urine in twenty-four hours, but we do not always know the kidney function of these patients, so probably it is wise, as advised by Maddock and Coller[3], Nesbit[4], Gamble[1], Solomon[5] and others, to maintain a 1500 cc. urinary output each 24 hours. Coller[2] has pointed out that a kidney which will concentrate only to about 1.01 requires a minimum of 1500 cc. to excrete the wastes put out normally by the kidney in a day. It should be remembered that the body first uses water for every other purpose and then gives the balance to the kidneys.

A source of constant loss, which amounts to about 1500 to 2000 cc. in a sick patient, is evaporation for heat regulation. This is called the insensible loss of water and is not water lost by sweating. This loss is from the skin and lungs. No salt is lost by this process.

From this we see that for the average postoperative patient, not very ill, we need to give 3500 cc. of fluid daily. This does not allow for the patient who has previously experienced abnormal loss of fluid from one source or another. The history is very important in determining whether there has been any lack of fluid intake or abnormal loss of fluid during the illness. This must be taken into consideration in planning to restore the fluid balance. A patient who is severely dehydrated from whatever cause is a poor risk until properly rehydrated. Symptoms of dehyration are dry skin and tongue, sunken eyes, hollow cheeks, scanty urine or an anuria. Coller's[2] work on dehydration is interesting and instructive. He put a group of normal individuals on a very low fluid intake and noted that the loss of weight was 5.7 per cent of body weight, that the urine was decreased in volume, that the nonprotein nitrogen was increased, that the blood became concentrated and that on the fourth

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day albumin and red cells appeared in the urine. These patients were given 6000 cc. of water and only put out 100 cc. of urine during the day in which this fluid was administered. This important point shows that a dehydrated patient must receive 3500 cc. of fluid for his daily average need plus 6 per cent of his body weight as additional fluids, thus making a total requirement for the average man of between 7000 and 8000 cc. for the first 24 hours.

After the dehyration has been corrected, the future plan must include the basic intake of 3500 cc. of fluid daily plus any amount lost by vomiting, estimation of drainage from intestinal fistulas or profusely draining wounds, severe diarrhea, profuse sweating, Wangensteen drainage and the like. The failure to consider these losses will often lead to a gradual dehydration with alkalosis or acidosis in spite of an intake of 3500 cc. of fluid daily.

Taylor[6] reports a patient who following operation for ruptured ulcer developed alkalosis and died. The patient was given 3500 cc. of 5 per cent glucose in normal saline solution daily but he had duodenal siphonage or Wangensteen drainage and had been losing 3000 to 8000 cc. of fluid through the duodenal siphonage for several days. When the condition was recognized and the carbon dioxide combining power of the blood was brought back to normal it was too late. The patient, having sustained the alkalosis for too long a period, died.

This brings up the problem of what alkalosis is and what its causes are. Alkalosis may result from hyperventilation of the lungs with its resultant excessive removal of blood, carbon dioxide, excessive ingestion of alkalis, pyloric obstruction or high intestinal obstruction which results in the vomiting of large amounts of chloride in excess of sodium. It also occurs in a small percentage of cases of diarrhea. Wright[7] describes the symptoms of alkalosis as loss of appetite, headache, irritability, nausea and vomiting. There also may be aching pains, twitching muscles, flushing, and weakness and the patient may pass into a state of prostration. Later tetany may, and often does, occur. Breathing is slow and the pulse rapid. If there has been no abnormal loss of fluids, the urine is alkaline and is increased in amount. Signs of renal damage such as the presence of albumin, casts, red and white cells frequently appear in the urine, and later evidence of renal insufficiency may occur with an increase in urea and nonprotein nitrogen. Death may come in coma apparently largely as a result of the uremia. For example, in a case of high intestinal obstruction, there is an increasing loss of chloride and fluid which causes an alkalosis and dehydration. Often in spite of this, there will be an acid urine and acetone in the urine. Wright[7] explains the acid urine by stating that the bicarbonate ion must be retained by the body fluids to replace the chloride ion and thus maintain the proper osmotic pressure of the blood. Acetone appears in the urine, according to Standard[8], because of starvation ketosis.

In obstructions low in the intestinal tract the tendency to alkalosis is not so severe, but there is a marked dehydration plus a loss of sodium chloride and a starvation ketosis. Standard[8] points out that physicians often feel comforted by the absence of vomiting in intestinal obstruction. This is not warranted, however, because the mere absence of vomiting is no insurance against dehydration and acid-base derangements. The fluid that is contained in the intestinal tract from overdistention in paralytic ileus cannot be absorbed and must be considered outside of the body. The treatment of these intestinal disorders is well established and consist of the overcoming of dehydration, the giving of sufficient sodium chloride and the overcoming of ketosis with glucose. These measures save many lives.

Acidosis occurs in starvation, from ingestion of large amounts of acid-producing salts, from diets designed to produce ketosis, from nephritis, severe diarrheas, diabetes and fistulas of the duodenum and jejunum because of the loss of very alkaline fluids. It should be remembered that severe dehydration often accompanies acidosis. It is interesting to note to what extreme dehydration in association with diabetic acidosis may occur. Root[9] reported a case of diabetic coma in which the patient was anuric and almost pulseless but recovered after having received 12000 cc. of normal saline and approximately

1200 units of insulin in a period of twelve hours. The patient did not begin to urinate until the last thousand cc. of normal saline was given. This is a very important point to those of us who treat diabetes. The water and the salt must be replaced in addition to metabolizing the glucose before diuresis can be expected and the acidosis corrected. Gamble[1] in his excellent work recently proved that the giving of sufficient sodium chloride plus the metabolizing of added glucose will correct acidosis. Root[9] made a very practical point when he stated that the giving of glucose to a diabetic in coma with a high blood sugar is unnecessary and only clouds the picture. The glucose level is already very high and added glucose is certainly of no value. It cannot act as a diuretic in the face of an existing dehydration. Acidosis is treated by correcting dehydration and the giving of sodium chloride and glucose to combat ketosis. In diabetic acidosis an excessive amount of glucose is already present and no more need be added. Though the use of normal saline solution is so essential in the treatment of dehydration, acidosis, and alkalosis, it should not be given indiscriminately. Coller[2] demonstrated this quite vividly in a study of ill surgical patients. One series received 3500 cc. of 5 per cent dextrose in normal saline solution and gained weight. A second series of cases received 3500 cc. of 5 per cent glucose in Ringer's solution daily and gained weight but to a lesser extent. A third series of cases received 3500 cc. of 5 per cent glucose in distilled water daily for three days and lost weight. This loss of weight was due to a loss of body tissues which were consumed as food. None of the entire series of patients was losing fluids in any abnormal manner. He also noted that those who were transferred from normal saline to 5 per cent glucose in distilled water promptly excreted an excess of urine above the total intake for twenty-four hours. Patients who do not lose any fluid through excessive perspiration or other abnormal channels lose very little sodium chloride, probably not over 0.2 gram a day; therefore, there is no indication for the administration of sodium chloride to these patients. That sodium is a factor in the retention of water was brought out by Mason[10] when he gave normal individuals 36 grams of sodium bicarbonate daily for three days and produced an everage gain of 2.28 pounds in weight. Straus[11] found that in toxemias of pregnancy the plasma proteins were often at, or below, the edema level and that the edema could be precipitated or aggravated by the intake of sodium bicarbonate or sodium chloride. On the other hand, the edema could often be controlled or eliminated by the restriction of sodium in the diet. The excessive use of saline solution may lead to edema, degenerative changes in kidney and heart muscle and edema of the lungs. The first sign of too much sodium chloride is usually dependent edema. However it should be remembered that loss of plasma proteins from profuse drainage of a wound or burns may cause edema which can be corrected by replacement of plasma proteins with blood transfusions. This edema is not caused by an excessive amount of sodium chloride but by a deficiency of plasma proteins.

What should be our guide as to how much fluid to give and what kind? It is always best to give the proper amount of fluid by mouth unless there is some contraindication to it. We must give 1500 cc. to allow for 1500 cc. of urine and 2000 cc. to allow for evaporation from the skin and lungs. This is sufficient provided there has been no abnormal loss through vomiting, diarrhea, sweating, or, as in the case of diabetes, excessive loss through the urine. These losses must be estimated or measured whenever possible and this amount added to the normal required intake. This is not sufficient if the patient has been losing excessive amounts of fluid and having an inadequate intake, but the deficiency must be taken into consideration and the fluid intake proportionately increased. A patient who is definitely dehydrated should receive the normal body fluid requirement of 3500 cc. plus fluid equivalent to 6 per cent of his body weight during the first day. A patient who has had an operation of thirty minutes' to one hour's duration, and who has been in good water balance prior to that time, according to Maddock and Coller[3], will lose about one liter of fluid from vaporization, loss of blood, urine, and vomiting during the operation and recovery

period. This patient should receive 1000 cc. of 5 per cent glucose in normal saline solution immediately and then 3500 cc. of fluid daily, preferably 5 per cent glucose in distilled water. If he lost fluids by abnormal channels there would also be a loss of electrolytes which should be replaced with normal saline solution. It is desirable to keep an accurate account of both the output of urine and any vomitus or drainage and an accurate record of the intake. It is particularly important to know the output from the stomach as in the case of Wangensteen drainage. Only in this way can one assure his patient of proper water balance. To give the total requirements as normal saline would be to invite edema and salt shock after a few days.

In the case of a patient with marked dehydration and chloride loss from the intestinal tract 5 per cent glucose and normal saline should be given until the salt content has returned to normal. The amount required may be enormous, running as high as 8000 to 12000 cc. on the first day. Five per cent glucose in Ringer's solution is equally valuable. Once the chloride has been restored to normal, the dehydration corrected, and there is no further loss of electrolytes, 5 per cent glucose in distilled water should be used.

If there is an acidosis or an alkalosis, how can sodium chloride and glucose alone correct it? The glucose helps to metabolize the fats and prevent ketosis. After dehydration has been corrected, the sodium chloride acts by replacing the bicarbonate ion with the chloride ion and the excretion of excess sodium. In acidosis, sodium is retained to combine with the bicarbonate ion and the chloride ion is excreted. This is not the whole story but is the practical side of the mechanism. Should we have a patient who has damaged kidneys and poor concentrating power, we must remember that he needs much more water for urine than the patient with normal kidneys, the reason being that if we allow an insufficient amount of fluid for urine the waste products which should be excreted cannot get out and there is a piling up of urea, nonprotein nitrogen, etc., and a decrease in the carbon dioxide tension. Such a patient will often do very well if a sufficient amount of 5 per cent glucose in distilled water, or plain water by mouth if tolerated, is given. Of course, if the patient has lost salt through excessive sweating, or by some abnormal means, the chlorides will have to be replaced. It is well to remember that if the patient has anuria due to dehydration all of the 50 per cent glucose, 50 per cent sucrose or concentrated saline will do no good but may cause further damage.

In summary, the majority of patients who have had no abnormal loss of fluid but need intravenous or subcutaneous fluid should get 5 per cent glucose in distilled water preferably intravenously, but it may be given safely under the skin, or I should say as safely as any subcutaneous injection may be given. The routine giving of normal saline solution over a period of days carries with it the danger of producing edema and excessive water retention.

In dehydration with alkalosis or acidosis 5 per cent glucose in normal saline solution, or 5 per cent glucose in Ringer's solution, should be given until the chloride deficiency and dehydration have been corrected.

The basic requirement of the average patient is 3500 cc. of fluid daily. A careful record should be kept of all fluid output and this added to the loss by vaporization. The fluid intake should balance the output and a careful record should be kept of it.

Loss of fluid from the intestinal tract should be replaced volume for volume by normal saline solution. Loss of fluid, when profuse, from wounds and burns should be replaced by normal saline solution and transfusions.

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INJURIES AT OR NEAR THE WRIST

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Injuries at or near the wrist are frequent. The consistent use of the x-ray in injuries about the wrist has demonstrated the presence of many fractures in lesions usually considered sprains, and has revealed a surprisingly large variety of fractures heretofore unknown. Likewise, the so-called Colles' fracture has been shown to be not a simple definite entity, but a deformity produced by a number of different lesions. It would seem, therefore, that the term "Colles' fracture" should either be abandoned or merely used to indicate the type of deformity that often results from these fractures. Classification of fractures near the wrist may be made on the basis of (a) the anatomical lesion, (b) the deformity produced.

ANATOMICAL LESIONS

1. Fracture of the diaphysis of the radius and ulna close to the epiphyseal line.
2. Fracture of the styloid process of the ulna.
3. Fracture of the styloid process of the radius.
4. Separation of the epiphysis of the radius and ulna.
5. Longitudinal fissure fracture of the radius.
6. Combination of one or more of the above fractures with or without fracture of one or more carpal bones.

DEFORMITY PRODUCED

1. Fracture with simple swelling about the wrist without deformity.
2. Fracture with Colles' or silver-fork deformity.
3. Fracture with reversed Colles' or Smith's fracture deformity.

It is readily understood that a lower radial fracture, when simply fissured, may show no deformity but the identical fracture, with displacement, may show a Colles' or reversed Colles' deformity. It will be convenient, therefore, to discuss these fractures grouped according to their deformities.

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ETIOLOGY

Direct violence, such as a blow near the wrist from a heavy falling object, or indirect violence may cause the injury. By far the most common cause is a blow or fall upon the hand, the type of fracture depending upon the position of the hand at the time of the fall, whether flexed or extended, abducted or adducted. Frequent, also, is injury from a kickback against the hand, of an automobile crank (chauffeur or Ford fracture).

PATHOLOGY: IN FRACTURES WITHOUT DEFORMITY

The lesions of the radius may be (1) oblique or transverse fracture through or separation of the entire styloid process; (2) an extension fracture or Barton's fracture, a chipping off of the posterior lip of the articular surface of the radius; (3) a flexion fracture or reverse Barton's fracture, a chipping off of the anterior lip of the articular surface of the radius; (4) multiple fracture of the epiphysis, often with longitudinal fissures extending up into the diaphysis; (5) slight epiphyseal separation; and (6) transverse fracture of the diaphysis just proximal to the epiphysis.

The ulna lesions may be: (1) fracture through the tip of the styloid process; (2) fracture through the base of the styloid process; (3) transverse fracture above the epiphysis or epiphyseal separation. All of the fractures may occur singly or a number of them may occur simultaneously.

The Colles' or silver-fork deformity results from an extension fracture, a fall or blow upon the hand in extension in which, as Pilcher has described, there is not only impaction of the carpus against the lower end of the radius, but there may be also splitting off of the lower radial fragments by descent of the upper fragment into it. The impact upon the lower end of the radius results in backward displacement of the lower fragment with, at times, outward displacement and a movement of rotation of the lower fragments in the direction of supination. There is usually

a transverse fracture of the radius just above the epiphysis within two or three cm. of the wrist joint, with or without comminution or impaction of the fragments. There may be radiating or longitudinal fractures of the epiphysis or of the radial shaft.

Associated with any of the above fractures, there may be fracture of the base or tip of the styloid process of the ulna, separation of the ulna epiphysis, laceration of the triangular interarticular cartilage and internal lateral ligament of the ulna, fracture of the scaphoid or semilunar, and dislocation of the os-magnum.

DIAGNOSIS

Fractures without displacements will show swelling of the wrist extending up the forearm, and localized pain; movement of the wrist may be limited and painful. Localized tenderness on palpation over the lower end of the radius and ulna is the most definite evidence. These fractures resemble sprains and cannot be differentiated from them in many cases without the x-ray. The diagnosis of fractures with Colles' deformity can usually be made at a glance. The dislocation above the wrist joint and the silver-fork appearance are characteristic. On the other hand, the actual lesion is a difficult matter to determine without a roentgenogram. All supposed sprains, therefore, should be subjected to roentgenography lest these fractures be overlooked.

The reverse Colles' or Smith deformity, results from a flexion fracture. It is comparatively rare. Cases have been described by Barton, Roberts, Pilcher and Smith. The radius is fractured at or near the epiphysis; the lower fragment is displaced anteriorly toward the palmar surface and the upper fragment and the end of the radius, dorsally, increasing the normal radial curve of the flexor surface. With this fracture there may also be fracture or dislocation of one or more carpal bones.

TREATMENT

In all severe injuries of the wrist, anteroposterior and lateral roentgenograms should be taken to determine the exact location and displacement of these fractures. However, in simple or so-called "sprains" of the wrist, by close inspection and palpation we can often get good results without subjecting our patients to the extra expense of roentgenography. In fact, many times it has not been or will not be convenient to have a roentgenogram made.

A correct diagnosis having been made, reduction should be accomplished as soon after the injury as possible. Complete reduction cannot usually be made satisfactorily without the administration of an anesthetic, either local or general. A number of times I have used a local anesthetic with gratifying results to both my patient and myself, by injecting from ten to twenty cc. of a one per cent novocain solution into the hematoma at the site of fracture. After the anesthetic has been administered, the next procedure is to reduce the fracture and immobilize it until union has taken place.

In reducing a Colles' or impacted fracture, it is sometimes necessary to use great force to accomplish a satisfactory reduction. Often it is from the use of too little force that a slight bony deformity remains after union has taken place. However, in the majority of cases, slight traction, hyperextension, traction and hyperflexion with a slight turn of the wrist, and abduction will force the radius into alignment. It requires knack rather than strength. The most important step in the treatment of Colles' fracture is breaking up the impaction and then the accomplishment of reduction. Too much emphasis cannot be laid on this statement. The surgeon should grasp the patient's hand as though he were shaking hands with him, the right hand with the right and the left hand with the left, grasping the lower end of the upper fragments,—that is, the forearm and wrist—with the other hand. The next thing to do is to break up the impaction. The surgeon should not be satisfied until he has actually recreated the fracture, and can elicit the sensation of crepitus.

The next step is the reduction of the fracture. This is accomplished by traction on the hand while pressure with the thumb is made upon the dorsum of the wrist and the index finger makes pressure upon the palmar aspect of the wrist; then with hyperextension, traction, hyperflexion and abduction. When reduction is complete the hand should be allowed to rest naturally without support to determine whether there is a recurrence of the deformity. If there is none, the fracture is properly reduced and may be fixed.

I would like to diverge at this point to say that if I should offer an explanation for ad-

dressing you, as some of you may say, "on such a simple every-day subject," it would be that my purpose is to outline to you what I consider the best and simplest treatment for this condition. You will find very little, if any, description of this treatment in any textbook on fractures. This treatment I learned many years ago from a noted surgeon of the "old school," Doctor Bodine of New York City. I have been using this technique for the past thirty-odd years with gratifying results. It is as follows:

Having diagnosed and reduced the fracture, it is now ready to be immobilized. If you will refresh your minds with the anatomy of the forearm, you will recall that the posterior or extensor surface of the radius and ulna is almost on a straight line from elbow to wrist, and a fixation splint placed on this surface will not only be comfortable, but will hold the fracture in position. Therefore, take a board splint about one-eighth of an inch thick, making it the width of the forearm from elbow to finger tips, having it slightly wider at the wrist so that you do not make undue pressure at this point; pad this splint well with cotton batting and apply a roller bandage on it to maintain a smooth surface. This board splint having been measured, cut and padded before reducing the fracture, you only have to put a light cotton padding around the arm from elbow to metacarpophalangeal articulation, over which you apply a light roller bandage. Then have a triangular cotton or gauze pad ready to apply to the dorsal aspect of the hand and apply a snug roller bandage over all, always paying special attention that you do not apply your bandage too tightly and obstruct the circulation. Also, be sure that you have the injured hand in the position of abduction, which is done by your triangular padding placed on the dorsal surface of the hand and the manner in which you apply your roller bandage, pulling the hand to the ulna side of the arm. Having applied the dressing, as above outlined, you have the fingers on the injured side free, and I always instruct my patient to use them freely and so continue throughout the treatment.

In healthy young adults I usually remove the splint at the end of about two weeks, massage the hand and arm, and reapply splint for another two weeks, when I usually remove the splint and apply a simple roller bandage about the wrist only, or have the patient get a wide athletic wrist support which he wears during the day, removing it at night. He is instructed to massage the hand, wrist and arm thoroughly, applying the support the next morning, and to continue this for about two weeks when all treatment may be discontinued.

In conclusion, I will say that if I have dropped one thought that may prove of benefit to you in treating this very common, and many times deforming and crippling, injury, I shall feel amply repaid for my efforts in presenting this subject for your consideration.

Box 430.

COOPERATIVE MANAGEMENT OF ALLERGIC RHINITIS

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In recent years enthusiastic reports by allergists conveyed the impression that allergic rhinitis is no longer a baffling problem. Rhinologists will take exception to such unwarranted enthusiasm. Twenty years' experience in combating nasal allergic disease has taught me that we are still groping in the dark, and while progress has been made, our therapy is still largely empiric. Although specific immunization is theoretically logical and probably the ideal, in practice the results have not met expectations.

While from a scientific point of view every patient with vasomotor rhinitis should have a systematic allergic investigation, the proportion in which such a study will yield negative results is high.[1] Most writers agree that in those cases in which an allergic cause cannot be determined, it will be necessary to resort to other forms of treatment. Conservative allergists recognize the fact that in allergic therapy we do not possess a panacea for all types of vasomotor nasal conditions.

ETIOLOGIC ASPECTS

The causative factors of allergic rhinitis are so varied that no specialty can claim the condition for its own exclusive domain. The more one considers the numerous theories that have been advanced, the more the etiology becomes confusing. There is no question regard-

Read before the Annual Meeting of the Florida Internists' Society, held at Daytona Beach, May 1, 1939.

ing the role played by offending allergens. Even if we do not accept specific immunization therapy as proof that desensitization can be effected, results from preventive measures provide sufficient evidence that there is an extrinsic influence, which usually becomes effective when the nasal membrane is hypersensitive.

Occasional successes with endocrine therapy suggest a causal relationship which should always be seriously considered. Why small doses of thyroid extract relieve the hyperesthetic symptoms in some cases of vasomotor rhinitis cannot always be explained. The large majority of these patients do not show low metabolic rates, even though many of them are on the minus side. It must be stated, however, that the myxedematous relationship pointed out by Novak[2] has more than passing significance, and that some attention must be paid to its potentialities in a certain group of such nasal allergic cases.

One cannot disregard the observation that the majority of women suffer nasal turgescence previous to or during their menstrual periods. Hoseason[3] again calls our attention to this condition, concerning which he states: "In an unlucky few the turgescence may give rise to even more severe symptoms. In some women the nasal congestion may result in an attack of vasomotor rhinorrhea; this is not an allergic reaction, but an exaggeration of a normal physiologic response . . . This type of vasomotor rhinorrhea which occurs in association with the menstrual function might be termed 'oestrogenic rhinorrhea'; but this does not mean to say that an allergic factor is necessarily excluded."

Jarvis[4] called attention to the color changes of the nasal mucous membrane, claiming that they serve as an index to the body chemistry of the patient. The red nasal septum syndrome, according to him, occurs in individuals who have a low tolerance for acid ash producing foods, medicinal acids or excessive output of muscular energy. A pale septum indicates a state of alkalosis. To the latter group belong the patients susceptible to hay fever, asthma, hyperesthetic rhinitis, coryza and bronchial infection. The treatment is based on the principle of dietary balance supplemented by drugs.

Though diet is not the all important etiologic factor in allergic rhinitis, it is of sufficient importance to merit individualized study. It has been found in some instances that patients who are dismissed by the allergist as "negative to all tests," actually have an allergic background.[5] Often the tests are improperly made, little attention being paid to the testing of foods in connection with abnormal conditions in the nose and throat.

An attempt has been made to explain that both vasomotor rhinitis and atrophic rhinitis are extremes approaching the pathologic in a physiologic variation in fluid content of tissues and to reconcile this variation on electrolyte control, especially of sodium.[6] "Therapy with the aim of forcing chemical change in the electrolyte pattern of body fluids on cases of vasomotor and atrophic rhinitis appears to support the view that fluid and sodium balance is the underlying cause for these clinical entities." (Kaplan[6]).

Benson Bloom[7] advances the view that allergy is predominantly a disturbance of electrolyte metabolism associated with some endocrine (possibly adrenal) dysfunction. Striking benefit was obtained from the use of potassium salts in a series of cases of hay fever. These salts are also employed in urticaria, eczema, nasal polyposis, chronic allergic sinusitis and migraine. In chronic asthma potassium chloride is apparently ineffectve; the use of potassium iodide, however, in combination with a salt-poor diet, seems helpful but not curative.

PROBLEMS IN DIAGNOSIS

While our review of the etiologic factors is incomplete it includes the more prominent current considerations. The diagnostic problem presents greater difficulties. The accuracy of a diagnosis will depend on whether the study is made by the rhinologist, the allergist, the internist, or by two or more specialists in cooperation. The symptomatology in itself is not a criterion for diagnosis. I have had the unfortunate experience of examining the noses of patients who have been unsuccessfully treated with injections for one to nine years only to find extensive local pathologic processes which made it impossible to effect immunization. It is illogical and unscientific to proceed with any therapy until a correct diagnosis has been made. The allergist has no right to attempt immunization until the completion of a careful examination of the nose and the sinuses. Neither has the rhinologist

any scientific authority to apply topical remedies until a systemic check-up has been made by the internist.

The value of allergic testing is not deprecated, especially if it is found that there is a single offender. If, however, the sensitizing agents are multiple, the information is of scientific interest but immediately minimizes the likelihood of favorable effects through immunization.

The diagnosis of allergic rhinitis requires more than an examination of the patient and a consideration of his symptoms. The successful treatment of this condition, as pointed out by Rackemann,[8] depends on the complete understanding of the patient and his particular problem. This author continues: "In the allergic diseases this is especially true because, as Pirquet has described, the symptoms depend on the peculiar capacity of the individual to react toward certain foreign substances. Not only must the physician understand the physiologic changes in the body of his patient, but particularly in the cases of hay fever, asthma, eczema and the other manifestations of allergy he must understand the patient's environment, his contacts with the various foreign substances that it may contain, and his reaction to these contacts. Recent clinical experience has led to the use of certain 'tricks' in history taking in allergic diseases which are of such practical importance that their recognition constitutes a virtual advance in diagnosis and treatment." I cannot here go into greater detail on this subject, since it is somewhat outside our scope. I do, however, want to bring this matter of history taking before you as one of the valuable aids for the diagnosis of allergic rhinitis.

The differentiation of allergic rhinitis from other upper respiratory conditions is at times difficult. It is now well recognized that allergy is the cause of frequent colds and chronic coughs. That these conditions are due to sensitization rather than bacteria, was suggested by Piness and Miller[9] and later confirmed by Clein[10] who carefully reviews the subject and makes a plea for the early recognition of the allergic state in childhood. Clein asserts that frequent colds may be interpreted as perennial or seasonal hay fever, and chronic persistent cough of this particular type as a preasthmatic symptom. "The early recognition of the allergic state in childhood, with proper diagnosis and adequate treatment, may prove to be the chief factor in the prevention of asthma and other major allergic disasters."

THERAPEUTIC CONSIDERATIONS

More could be said on the subject of diagnosis, but I must restrict myself to the subject under discussion. What has been said with regard to etiology and diagnosis is preliminary to a consideration of the cooperative management of allergic rhinitis. Dean[11] emphasized that every patient presenting a boggy mucous membrane should be subjected not only to a complete allergic but also to a dietary, bacteriologic and endocrine investigation. He remarks: "One of the essential things in the treatment of allergic rhinitis is that the patient should be under the care of a rhinologist . . . A second essential in the treatment of allergic rhinitis is a most careful study of the patient."

I have made it a practice in every case of allergic rhinitis to follow this plan. Earlier experience has taught me that local measures may relieve and even cure a small percentage of patients, but in the large majority more than topical remedies will be required. On the other hand, I have learned that frequently local procedures are valuable adjuncts to allergic, endocrine and other forms of therapy. There is no single drug or procedure which can be employed routinely with success. Nor can we scientifically combine measures without adequate laboratory and clinical evidence. Utilization of certain local procedures on an empiric basis, is, in my opinion, justified when failure has resulted from a comprehensive course of indicated treatment. It is in this group of stubborn and resistant cases that I have advocated the use of zinc iontophoresis as a simple, safe and effective means of affording prolonged palliation.[12, 13]

Nearly every specialist is confronted at one time or another with patients suffering from some form of allergy. "Although the various manifestations of allergy frequently coexist in a greater or lesser degree, it is the predominating one which directs the patient to the internist, the gastro-enterologist, the dermatologist, the ophthalmologist, or the otolaryngologist . . . The high incidence of manifestations in the nose and paranasal sinuses necessitates a close correlation with the various other phases of allergy, for nasal allergy always suggests that other accompany-

ing symptoms may also be of an allergic nature. (Hansel.[14])

The treatment of allergy is a much larger problem than we were first led to believe. The rhinologist is qualified to look after the nose, the allergist after the allergic symptoms, but it is the internist who gives us important data concerning the state of the body as a whole. The allergist cannot successfully treat allergic rhinitis without the cooperation of the rhinologist and the internist. This likewise applies to the rhinologist and the internist. When one seriously considers, as Hansel has pointed out, that careful and scientific management embraces classification of the patient according to the seasonal occurrence of the symptoms and the etiologic factors concerned, the degree of pathologic change in the nose and paranasal sinuses, the presence or absence of infection, the association of other manifestations of allergy, and the influence of secondary factors, then it requires no further argument that failures in the treatment of allergic rhinitis have been due to lack of coordinated effort. If this paper accomplishes no other purpose, let it represent a plea to overcome this deficiency in the future.

I am not so enthusiastic as to assume that even with cooperative effort our results will be perfect. Allergic rhinitis is too complex a condition. In the light of our present knowledge, however, and until that time when investigations will throw more light on the true etiologic background of allergic diseases, we must accept cooperative management as the most rational approach to the problem.

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ASSOCIATION MEMBERSHIP

The steady growth of the State Medical Association is evidenced by the increase in its membership. As this Journal goes to press the membership totals 1,330, as compared to 1,293 for the previous year. When your present secretary and managing director took office the total paid membership was only 645.

The strength of the Association as a whole lies largely in the hands of the thirty-four component medical societies. These individual units of the State Association are headed by capable and enthusiastic officers and the entire membership has been working with unusual harmony over a long period of years. As an indication of interest and enthusiasm of the local units, for the past two years the Marion County Medical Society has been the first to report one hundred per cent of its membership paid. This year Dr. R. C. Cumming, secretary of the Marion County Medical Society, reported over long distance phone on December 26 that his society's membership was one hundred per cent paid for 1940 and that a check remitting the membership dues was in the mail. On January 1, Dr. R. B. Spires, secretary of the Walton-Okaloosa County Medical Society, reported that society's membership one hundred per cent paid for 1940. This is a concrete illustration of the efficiency and enthusiasm existing in the component county medical societies.

The home office of the state association belongs to its members and will be conducted according to the policies and instructions laid down by its members through their officers. Every member is invited and urged to visit the home office and contribute suggestions and constructive criticism, in order that activities may be directed, as far as possible, according to the wishes of the entire membership.

1940 CENSUS WILL BRING VALUABLE VITAL STATISTICS

While the inventors of diabolic instruments of war have been ingeniously practicing their craft, the scientific forces engaged in the preservation of life have made even greater progress. Records of the U. S. Bureau of the Census indicate that depletion of population by deaths on the battlefields is of relatively small account, when balanced against the results of the less publicized but equally dramatic contributions to the prolonging of human lives now being made by medical science.

It is possible, through Census records, to make interesting comparisons, for example, of death rates prevailing around 1900 and those of today. If the 1900 figures still governed, over 450,000 more deaths would occur this year in the United States than actually will take place.

In 1900, for instance, tuberculosis caused 201.9 deaths per 100,000 population. Now it causes but 53.6. Using the 1900 ratio against a present estimated U. S. population of 132,000,000, 188,500 Americans who otherwise would die are *not* dying this year from this cause alone—a cause which in the aggregate has cost more lives than the toll exacted in all the wars of history. This year, the prevention of deaths from tuberculosis will save more than four times as many people as the number of American soldiers killed on all the World War battlefields.

The Division of Vital Statistics in the Census Bureau keeps accurate records on the 15 maladies against which medical science has made its greatest advances. These are tuber-

culosis, typhoid, smallpox, measles, scarlet fever, diphtheria, influenza and pneumonia, erysipelas, malaria, bronchitis, diarrhea and enteritis, cirrhosis of the liver, maternity deaths, congenital malformations and diseases of infancy, and nephritis. For these fifteen, the net reduction of deaths per year per 100,000 people has been 542, which would indicate a saving of 704,600 lives this year as against the 1900 mortality rate.

It is essential that every citizen lend his full cooperation toward making each census a complete one. At least one phase of the 1940 enumerations—the Census of Population—will touch every person in America directly, and many people will be queried on two or even more of the various schedules.

Answers to Census questions are required by law, but the same statute requires the Census Bureau to maintain its long-established policy not to disclose any facts about individual persons or establishments. Individual reports are not available to any other government department. Assurance thus is given that reports to the Bureau will not be used for taxation, regulation, or investigation.

THE RECORD REFUTES CHARGES THAT A. M. A. IS REACTIONARY

"While captious critics have been denouncing the American Medical Association as reactionary and obstructive, its members have been conducting numerous and extensive experiments during the last seven years in search of ways of organizing payments for medical service and adjusting the burden of medical cost to the abilities of varying economic classes," *The Journal of the American Medical Association* for Dec. 30 declares.

"Never have so many, so varied or so significant projects been carried out in any other country. When the burden of medical care for the indigent disrupted the systems of county and township doctors, drained the resources of philanthropic organizations and became too heavy for gratuitous service by physicians to bear, the various state and county medical societies developed almost the only successful plans for efficiently distributing such resources as were available to provide medical care for the indigent.

"During the period 1932 to 1938, between 200 and 300 county societies entered into contracts with relief authorities to provide medical service for the indigent. These were organized to include such protection to the interests of the patients and the public as free choice of physician and economical administration of the always insufficient funds. A number of county societies have also experimented with medical service bureaus for the low income classes. Some of these bureaus are still in operation and have been helpful to many persons in this class in enabling them to meet the costs of needed medical care. All these plans and all those which are now in operation are considered frankly as experiments to be expanded, restricted, altered or abolished as they prove their value in protecting the health of those served. If they are not found desirable they may be abandoned. The medical society stands the loss in time and money expended, but no political, financial or occupational vested interests are created and left behind to hamper further experiments."

PRESIDENT'S HOSPITAL PROGRAM RECOGNIZES THE A. M. A. PLATFORM

"On December 22 President Franklin D. Roosevelt, in his regular interview with the press, gave definite intimation as to his point of view relative to proposed legislation in the field of health," *The Journal of the American Medical Association* for Dec. 30 states in an editorial. After summarizing the interview the editorial goes on to point out that the reported views of the President are a recognition of some of the objectives of the Association's platform and that the facilities, help and advice of the Association's Board of Trustees and officers are available to the government in working out any sound plan for meeting immediately any health needs which may be demonstrated. The editorial continues:

According to a report from the United Press he said that the administration is considering a program for federal construction of hospitals in areas where such facilities are lacking, and he intimated that the plan might be recommended to the coming Congress. According to the United Press, he said the program, if undertaken, would start modestly but could be enlarged as desired. No estimate of the cost has been completed, but the President emphasized, says the report, that it would cost less than the more extensive health and school programs proposed in bills introduced by Senators Robert F. Wagner, of New York, and Pat Harrison, of Mississippi.

According to the United Press, his comments indicated that he is dissatisfied with both these measures. He said that the Wagner or Harrison bills would cost a lot of money and that the chief trouble was in the requirements for states to match federal funds. The new program he outlined would provide that the government bear 100 per cent of the hospital construction costs, retain title to the institutions and build them only in areas where local interests offered satisfactory assurances that they would operate and maintain the institutions.

Under a matched program, Mr. Roosevelt is said to have pointed out, those states which have the most money could obtain the most federal funds. "They already have the best hospitals and health conditions, he pointed out," says the United Press report, "while the poorer states have a lower health level and insufficient funds to obtain federal money on a matched basis. Since elimination of the PWA 55-45 matched money program, the President said, the federal government could afford to finance in a small way medical centers in those areas needing them. He suggested fifty hospitals as a start. He pointed out as an example one New York county of 100,000 population with six good hospitals and three Southern counties of the same population without any medical facilities. The cost of the program he has envisioned would not be great, but it would mark the first experimental steps to bring health facilities to those areas needing them most, he explained. The major part of the work would be done by the WPA as far as possible, he said. The Public Health Service and a committee of doctors would pass on the plans and determine the ability and willingness of localities to operate and maintain the institutions. The President said he had talked over the plan with a number of doctors and will discuss it soon with the American Medical Association.

"He said doctors from many locales had told him they were unable to raise capital to build hospitals but that if they could get small plants they could maintain and operate them. As outlined by the President, each institution would consist of a one story hospital building of two wings, one each for white and colored persons, and an administration building with clinic, operating room and laboratory. He estimated that each hospital would provide 100 beds at a cost of around $150,000. The President emphasized that his program is no grandiose scheme for putting up hospital centers costing $10,000,000 each and he said he did not think the medical association's objections to government health programs would apply to such small hospitals. The President said that Miss Josephine Roche, former Assistant Secretary of the Treasury, was remaining with his Interdepartmental Committee on Health, but he said it did not mean that Security Administrator Paul V. McNutt was being eased out of the health program. He said a story to that effect about McNutt was crazy and made out of whole cloth."

Thus the President has recognized some of the objectives of the platform of the American Medical Association. He has recognized the primary objection inherent in the principal of grants-in-aid. The American Medical Association has approved the development of medical facilities where need can be shown, with provision for local administration and control. It has opposed the grandiose plans of the Wagner bill. The Board of Trustees and the officers of the American Medical Association have repeatedly offered their facilities and help and advice to the government in working out any sound plan for meeting immediately any needs which may be demonstrated.

WARNING OF IMPOSTORS

At this time of the year there are always a number of undesirable transients in the state and almost every winter doctors are swindled through patronizing unknown agents.

Last January at least two of our members suffered the loss of surgical instruments which a well appearing and plausible salesman, working under the name of Morrison as a representative of the Morrison Co. (apparently nonexistent), purported to take up for the purpose of replating and repairing. Nothing further was ever heard of him.

For their own protection our members should refuse to pay a deposit to an unknown salesman or entrust him with any article of value without first making an investigation. The Association will be glad to cooperate in securing information regarding unknown characters who work among the doctors.

INTERNATIONAL COLLEGE OF SURGEONS

The United States Chapter of the International College of Surgeons (Geneva) announces its Fifth Assembly Conference, February 12-14, 1940, at the Florida Medical Center, Venice, Florida. The following distinguished speakers will appear on the scientific program:

DR. MOSES BEHREND, Philadelphia, Pa.
"The Role of Extrapleural Pneumothorax in the Treatment of Pulmonary Tuberculosis."

DR. WM. J. CARSON, Milwaukee, Wisconsin.
"Retroperitoneal Lipoma."

DR. WARREN B. DAVIS, Philadelphia, Pa.

DR. TEMPLE FAY, Philadelphia, Pa.
"Refrigeration in Human Beings and Its Effect on Undifferentiated Cells Particularly Related to Cancer, a New and Important Subject."

DR. ALBERTO INCLAN, Havana, Cuba.
"Surgical Treatment of Giant Cell Tumors of Bones."

DR. CHEVALIER JACKSON, Philadelphia, Pa.

DR. WM. R. LOVELACE, Albuquerque, New Mexico.

DR. WILLIAM E. LOWER, Cleveland, Ohio.
"The Indications for and the Result of Ureteral Transplantation into the Recto-Sigmoid."

DR. MANUEL A. MANZANILLA, Mexico City, Mexico.
"Vaterian Pseudodiverticulum of the Duodenum."

DR. RUDOLPH NISSEN, Istanbul, Turkey.
"Reconstruction of the Ureter."

DR. BRADLEY M. PATTEN, Ann Arbor, Michigan.

DR. LEWIS F. SMEAD, Toledo, Ohio.
"Management of Acute Hemorrhagic Pancreatitis."

DR. CARL STEINKE, Akron, Ohio.
"Treatment of Complications of Penetrating Wounds of the Thorax and Associated Injuries."

DR. THEW WRIGHT, Buffalo, New York.

DR. HUGH YOUNG, Baltimore, Md.

All members of the Association are invited to attend all of the scientific sessions. For further information, communicate with Dr. Julien C. Pate, 1101 First National Bank Building, Tampa.

MEDICAL LICENSES GRANTED

Dr. W. M. Rowlett, secretary of the State Board of Medical Examiners, reports that of thirty-two applicants who took the State Board of Medical Examiners' examination in Jacksonville on November 13 and 14, twenty-nine were successful and have been issued licenses to practice medicine and surgery in Florida. The names and addresses of the successful applicants are as follows:

Walter O. Allen; Hendersonville, N. C. (S. C., 1926).
Phillip M. Bichard; Episcopal Eye, Ear and Throat Hospital, Washington, D. C. (Louisiana, 1935).
Jackson L. Bostwick; St. Luke's Hospital, Jacksonville (Tulane, 1939).
Lee E. Bransford, Jr.; Duval County Hospital, Jacksonville (Temple, 1939).
Glenn W. Bryant; Grady Hospital, Atlanta, Ga. (Louisville, 1938).
Joseph M. Caputo; 27 Division Street, Lake City (Marquette, 1935).
Thomas S. Carter; Riverside Hospital, Miami (Vanderbilt, 1932).
Frank N. Cooke; 307 Cottage Avenue, Jacksonville (Temple, 1939).
Hilbert N. Dricken; 607 North 23rd Street, Milwaukee, Wis. (Marquette, 1935).
Donald H. Gahagen; Windber Hospital, Windber, Pa. (Temple, 1939).
A. Judson Graves; University of Pennsylvania Hospital (X-Ray Department), Philadelphia, Pa. (Georgia, 1933).
George D. Hoffeld; 156 Third Street, Troy, N. Y. (Long Island, 1931).
Leo Honigsberg; 845 Collins Avenue, Miami Beach (New York, 1928).
Emil M. Isberg; 1552 Euclid Avenue, Miami Beach (Michigan, 1938).
O. L. Kelley; Emory University Hospital, Emory University, Georgia (Emory, 1939).
John M. Kibler; 430 Fifth Street, South, Rochester, Minn. (Johns Hopkins, 1935).
Charles Lippow; 201 Eastern Parkway, Brooklyn, N. Y. (Bern, 1917).
John W. Meredith; Scottsville, Ky. (Chicago, 1933).
H. Gerald Morin; Mound Park Hospital, St. Petersburg (Rochester, 1938).
John W. Pender; Carthage, Miss. (Tulane, 1935).
Richard Reeser, Jr.; 525 Third Street, S. W., Rochester, Minn. (Cornell, 1935).
Max Resnicoff; 141 Joralemon Street, Brooklyn, N. Y. (New York, 1917).
Ralph S. Sappenfield; 111 East 26th Street, New York, N. Y. (Indiana, 1930).
Randolph Shevach; care Kings County Hospital, Brooklyn, N. Y. (Long Island, 1936).
Maurice A. Shinefeld; 4601 Post Avenue, Miami Beach (Rush, 1937).
Charles W. Smith; 1108 Colquitt Avenue, N. E., Atlanta, Ga. (Emory, 1937).
William J. Sweeley; Opa-Locka (Rush, 1932).
Ellsworth F. Waite; Box 57, Worcester, Mass. (Boston, 1936).
Leo A. Zuckerman; 365 Broadway, Saratoga, N. Y. (Albany, 1936).

Dr. Rowlett also reports that forty doctors of medicine took the first Basic Science Board examination, held in Gainesville on November 4. There were five failures before the Basic Science Board.

CORRESPONDENCE

MEDICAL WRITING SERVICE

To the Editor:

As an editor of wide experience dealing constantly with editorial problems, you may be interested in letting the readers of The Journal know of the medical writing service I am prepared to offer the members of the Florida Medical Association. This service is designed to assist the physican who writes in the way that will be most helpful to him.

The volume of material submitted for publication today indicates on the part of the profession a growing awareness of the importance of medical writing in the making of a successful physician. The presentation of papers before societies brings him and his work to the attention of hundreds; through their publication he becomes known to thousands. Also, the more he writes, the better he himself becomes informed on the subjects he discusses.

Along with the editor, the experienced medical essayist knows that a well prepared paper on a practical, timely subject, that is of interest to a reasonable number of readers, is always acceptable for publication. No subject is overworked so long as new, scientific evidence pertaining to it is forthcoming. The paper that contains new thought, original observation or record of experience is sure to be favorably received.

It happens, however, that many articles cumber the literature today which neither elevate its tone nor add to the knowledge of scientific medicine. Too frequently an author, often responding to the demand of a medical society for a contribution to its program, selects his subject haphazardly and writes indifferently from a sense of duty. His paper, even when based only on textbooks and easily accessible literature, serves a useful purpose as a basis for a general discussion in the society before which he presents it, and he is perhaps warmly congratulated by its members. Once such a paper is resolved into cold type, however, without the personality and inflections of the author to embellish it, the reader's eye readily perceives the faults that the listener's ear failed to detect.

As a careful editor you are well aware that a surprising number of papers are rejected because they are written for reading, not for printing. Some are ungrammatical, verbose, discursive, poorly organized and without sequence in argument or arrangement of subject. Others lack brevity and conciseness; they are rambling and weighted with unnecessary details. They may contain colloquial language and personal allusions as well as material that is unrelated and irrelevant. It has been well said that a manuscript that is fit to read is sometimes fit to print, but a manuscript that is fit to print is always fit to read.

The service offered enables the medical essayist to have the literature on whatever subject he chooses reviewed and summarized or abstracted. Once he has written a paper, whether in rough draft or more finished style, he may have it edited and typed in proper form for publication; or assistance will be given in the initial drafting of the article. He may have prepared for publication the report of a case that he desires to place on record. If interested in a medicolegal problem, he may procure a resume of the medicolegal aspects of the subject in question. Also, he may obtain aid in the preparation of an informal talk or public address. The fees for these services are reasonable.

It is the aim of this service to save the medical author both time and effort by giving assistance in whatever form he finds most useful. At the same time, it would insure for him a paper not only suitable for reading but also acceptable to the most discriminating editor. I trust the members of the Association will be interested in this type of service.

Very truly yours,
Edith B. Hill

935 South Oregon Avenue, Tampa.

BIRTHS

Dr. and Mrs. P. H. Guinand of Clearwater announce the birth of a daughter, Mary Matile, on December 14, 1939, at Morton Plant Hospital.

STATE NEWS ITEMS

Dr. Walter C. Jones of Miami was elected to Fellowship and Dr. Gerry R. Holden of Jacksonville was advanced to Senior Fellowship in the Southern Surgical Association at its meeting held in Augusta, Ga., December 5 to 7, 1939.

* * *

On December 4, 5 and 6 an institute on tuberculosis was held at the State Tuberculosis Sanatorium at Orlando, especially for county health officers. Eighteen counties were represented. Discussions were lead by Dr. R. D. Thompson, superintendent and medical director of the State Tuberculosis Sanatorium; Dr. A. B. McCreary, State health officer; Dr. J. A. Kelk, Dr. L. H. Kingsbury and Dr. W. O. Fowler.

* * *

The Radiological Society of North America met in Atlanta, December 11-15. Dr. O. O. Feaster of St. Petersburg is chairman of the Executive Committee for the ensuing year; Dr. J. C. Dickinson of Tampa was reappointed a member of the Legislative Committee; Dr. Frazier J. Payton of Miami Beach was reappointed councilor for Florida; and Dr. F. K. Herpel of West Palm Beach served as a member of the nominating committee.

Florida doctors who attended: F. J. Mantell, Bay Pines; J. Maxey Dell, Jr., Gainesville; John A. Beals, Thomas H. Lipscomb, Jacksonville; John J. Jares, Lakeland; Frazier J. Payton, Miami Beach; John N. Moore, Ocala; J. A. Pines, Walter A. Weed, Orlando; Annette Feaster, O. O. Feaster, J. A. Herring, St. Petersburg; H. O. Brown, J. C. Dickinson, Charles M. Gray, Tampa; F. K. Herpel, West Palm Beach.

* * *

Dr. A. B. McCreary of Jacksonville was elected president of the Florida Public Health Association at its eleventh annual meeting held in Jacksonville in December. The State Medical Association is honored to have one of its members thus recognized.

The annual meeting of the Suwannee River Medical Society was held in Live Oak Thursday, December 14. The guest speaker of the evening was Dr. J. Ralston Wells of Daytona Beach, whose subject was "Severe Toxic Thyroid." The newly elected officers for 1940 are Dr. Thomas H. Bates, Lake City, president; Dr. Harry S. Howell, Lake City, secretary-treasurer. The next meeting will be held in Lake City.

C. E. TUMLIN

The death of Dr. C. E. Tumlin, long a member of the State Board of Medical Examiners, was deplored by that body in the following Resolutions which were recently adopted:

WHEREAS, the Florida State Board of Medical Examiners has suffered a loss in the sudden and untimely death of Dr. C. E. Tumlin, a most valuable, stalwart, respected and beloved member, and

WHEREAS, Dr. Tumlin was a faithful and efficient member of the Board, serving since September 24, 1930, and having held the offices of vice-president and president.

He gave cheerfully of his time and talent to every cause intended to strengthen and benefit the Board, having always been a true disciple of the principles of organized medicine, always maintaining the highest standard of ethical relationship.

RESOLVED, That in the death of Dr. Tumlin the Board has lost a member whose place will be hard to fill, whose active interest will be sadly missed, whose devotion to its best interests has been largely responsible for its development and influence in the establishment of the present high standard of medical licensure in Florida.

RESOLVED, That we deplore the loss of Dr. Tumlin and feel the loss of this member very deeply, that each member of the Board is grieved, and extend to his family our deepest sympathy.

BE IT FURTHER RESOLVED, That the State Board of Medical Examiners of Florida offers condolence to the bereaved family in this hour of sadness over their departed member and that a copy of these resolutions be sent to his bereaved widow and family and the State Medical Journal.

B. A. Chapman,
Thomas W. Hutson,
Carl Williams,
Committee.

COMPONENT COUNTY SOCIETIES

BAY COUNTY MEDICAL SOCIETY

At the meeting of the Bay County Medical Society held December 14, the following officers for 1940 were elected: President, A. H. Lisenby; vice president, W. E. Middlebrooks; secretary-treasurer, W. C. Roberts. Doctor Roberts was elected delegate to the convention in Tampa for 1940 and Dr. J. M. Nixon elected alternate delegate.

Dr. M. F. Parker from Greenville, Alabama, has recently become a member of the Lisenby Hospital Staff, with offices in the hospital, and associated with Dr. A. H. Lisenby. He will engage in general practice. Doctor Parker was admitted to the membership of Bay County Medical Society for 1940.

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DADE COUNTY MEDICAL SOCIETY

At the December meeting of the Dade County Medical Society, the following officers were elected to serve for 1940: President, Joseph S. Stewart, Miami; vice president, Wiley Sams, Miami; secretary, Franz Stewart, Miami; treasurer, W. L. Fitzgerald, Miami.

* * *

DE SOTO-HARDEE-HIGHLANDS-CHARLOTTE-GLADES COUNTY MEDICAL SOCIETY

The members of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society held their December meeting at the Hotel Simmons, Wauchula. Following a sumptuous turkey dinner, a round table discussion was held.

* * *

DUVAL COUNTY MEDICAL SOCIETY

Dr. Charles B. Mabry was installed as president of the Duval County Medical Society at a meeting held on December 5, and Dr. S. R. Norris was designated as president-elect. Other officers who were named were: vice president, James M. Bryant; secretary, Lauren M. Sompayrac; and treasurer, Alan Brown.

* * *

ESCAMBIA COUNTY MEDICAL SOCIETY

At the meeting of the Escambia County Medical Society held at the Pensacola Hospital, December 12, the following officers were elected: President, Sidney G. Kennedy, Pensacola; vice president, W. P. Hixon, Pensacola; secretary-treasurer, W. E. Tugwell, Pensacola; delegates, H. L. Bryans and C. C. Webb; alternates, L. C. Fisher, Jr., and J. N. McLane.

* * *

HILLSBOROUGH COUNTY MEDICAL SOCIETY

At the election of officers held by the Hillsborough County Medical Society on the evening of December 5, the following were chosen to guide the destiny of the society for the coming year: President, John R. Boling, Tampa; vice president, J. C. Pate, Tampa; secretary-treasurer, James S. Grable, Tampa. The delegates who will represent the society at the next meeting of the State Association are: W. M. Rowlett, R. S. Torbett, H. Mason Smith, J. W. Alsobrook, and T. C. Maguire.

* * *

LAKE COUNTY MEDICAL SOCIETY

The annual meeting of the Lake County Medical Society was held at the Medical Center, Eustis, on the evening of December 7. Officers were elected as follows: President, W. L. Ashton, Umatilla; vice president, Marion B. O'Kelley, Leesburg; secretary-treasurer, G. Oliver Emerson, Tavares.

* * *

MARION COUNTY MEDICAL SOCIETY

Again the Marion County Medical Society captures the honor of being the first society in the state to report 100% dues paid. A check covering 1940 dues for the entire membership of this society was received by the State Association the latter part of December. We believe this establishes an all-time record for promptness in the complete payment of dues by any society. Congratulations, Marion County Medical Society!

* * *

PALM BEACH COUNTY MEDICAL SOCIETY

The regular meeting of the Palm Beach County Medical Society was held on November 27, at the Tuscawilla Club, inaugurating a new idea of combined dinner and business meeting. After the business session, a sympo-

sium on Diabetes was held with papers read by the following doctors:

1. Presentation of Case—T. Z. Stanley.
2. Preoperative and Postoperative Treatment of the Surgical Diabetic—W. W. George.
3. Diabetes Simulating the Acute "Surgical" Abdomen—V. D. Stone.
4. Amputation in Diabetes—S. W. Fleming.
5. Mechanism of Acidosis in Diabetes—V. M. Johnson.

The attendance was 77.58%.

The December meeting of the society was held on the 18th at the George Washington Hotel, West Palm Beach. Election of officers was held which resulted as follows: President, James H. Pittman, West Palm Beach; vice president, W. O. Arnold, West Palm Beach; secretary, C. J. Derrick, West Palm Beach; treasurer, F. K. Herpel, West Palm Beach; delegates, L. J. Netto, F. K. Herpel, and James H. Pittman; alternates, S. W. Fleming, W. W. George, and W. E. VanLandingham.

* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. W. H. Walters entertained the Pasco-Hernando-Citrus County Medical Society at the hotel in Lacoochee, Thursday evening, December 14. A quail dinner was served by the host and enjoyed very much by all those present.

The following officers were duly nominated and elected: Dr. W. H. Walters, Lacoochee, president; Dr. W. B. Moon, Crystal River, 1st vice president; Dr. S. C. Harvard, Brooksville, 2nd vice president; and Dr. G. R. Creekmore, Brooksville, re-elected secretary-treasurer. Dr. W. H. Walters was elected delegate to the State Medical Association meeting with Dr. Claude L. Carter as alternate delegate.

Dr. James L. Estes of Tampa, the invited guest, gave a very interesting report on abscesses.

Those present were: Drs. Claude L. Carter, G. R. Creekmore, Edw. H. Brown, Geo. A. Dame, S. C. Harvard, W. W. Jones, W. H. Walters, and James L. Estes.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a dinner meeting at the Clearwater Yacht Club, Clearwater, on the evening of December 1. Dr. M. A. Nickle read an interesting paper on "Vertigo" and Dr. John Shahan presented several case reports, illustrating his talk with x-ray plates.

* * *

POLK COUNTY MEDICAL SOCIETY

The December meeting of the Polk County Medical Society was held at Bartow on the evening of the 13th. The following officers were elected to serve during 1940: President, Henry Fuller, Mulberry; vice president, W. F. Peacock, Bartow; secretary-treasurer, J. W. Annis, Lakeland; delegates, Herman Watson, R. L. Cline, J. R. Boulware, Jr.

Dr. C. H. Murphy presented a paper on "The Thymus Gland" as a feature of the scientific program.

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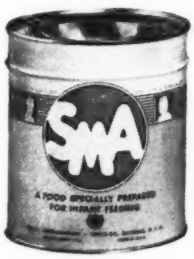

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SARASOTA AND MANATEE COUNTY MEDICAL SOCIETIES

A joint meeting of the Sarasota and Manatee County Medical Societies was held November 21 at the Whitfield Estates, Sarasota. Dr. W. E. Wentzel of Bradenton and Dr. Robert T. Nelson of Tampa were featured speakers. Doctor Wentzel reported on a recent survey of hookworm in the Manatee County schools and Doctor Nelson presented a paper on "The Management of Difficult Obstetrical Cases."

* * *

SEMINOLE COUNTY MEDICAL SOCIETY

Dr. Wade H. Garner was elected president; Dr. G. S. Selman, vice president; and Dr. Douglas G. Scott, secretary-treasurer at the annual election held in connection with the December meeting of the Seminole County Medical Society.

As a feature of the scientific program, Dr. E. E. Hitchcock of Orlando presented an interesting paper on "Diarrheas in Infants and Children."

* * *

VOLUSIA COUNTY MEDICAL SOCIETY

The election of officers was held by the Volusia County Medical Society at a meeting on December 12 at the Halifax Hospital, Daytona Beach. Those elected were: President, L. V. L. Brown, DeLand; vice president, J. R. Chandler, Daytona Beach; secretary-treasurer, R. L. Miller, Daytona Beach.

A general discussion of the proposed Volusia County Health Unit was held and a committee of five doctors appointed to work out further details of the management of such a unit. Serving on this committee are Drs. J. Ralston Wells, L. W. Glatzau, Ludo von Meysenbug, Hugh West, and W. C. Chowning.

* * *

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

The second society on the honor roll of 100% paid societies is the Walton-Okaloosa County Medical Society whose check for 1940 dues covering the entire membership was received at the State Association office on January 2. Congratulations!

The society is headed this year by Dr. A. G. Williams of Lakewood, president, and Dr. R. B. Spires of DeFuniak Springs, secretary-treasurer.

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

The Minimum Incidence of Intestinal Protozoa in a Representative Sampling of the Adult Population in Florida, BORLAND, JAMES L., Jacksonville, *South. M. J.* 32: 364-370 (Apr.), 1939.

The minimum protozoal incidence in Florida was found to be 22 per cent. The incidence of *Endamoeba histolytica* was found to be 6 per cent, *Endamoeba coli* 9 per cent, *Endolimax nana* 7.4 per cent, *Giardia intestinalis* 5.6 per cent, all others in small amounts. These figures are high enough to make protozoal infections important in diagnosis, though no more in Florida than elsewhere, as these figures compare favorably with those in other parts of the country.

The technic of collection of specimens in order to find these parasites is of paramount importance, as is also the method of examination of stools. It is emphasized that a single negative examination on a suspected case of amebiasis is worthless, and that at least six defecated specimens should be examined, these six to include one after a purge, and one the day after a purge; also one specimen should be obtained by sigmoid lavage.

The incidence of protozoal infections is higher in those in the higher income levels, and higher in persons who have been to the tropics.

The author emphasizes that Endamoeba histolytica was never found in patients in whom no inflammation of the large intestine could be demonstrated, and he makes a plea for a wider appreciation of the possibility of protozoal diseases in some of the obscure and unimproved gastro-intestinal disorders, or even in the absence of any intestinal symptoms.

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, American Journal of Syphilis, Gonorrhea and Venereal Diseases, Vol. 23, No. 2, pages 201-206, March, 1939.

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My Dear Auxiliary Friends:

Time flies all too swiftly!

As your President let me extend delayed Greetings: "With every good wish for the New Year."

On Wednesday night, December 13, I had the pleasure of visiting the Polk County Medical Auxiliary at a dinner meeting held in the New Oaks Hotel, Bartow. This Auxiliary has a well rounded out program and is a splendid organization. The Student Loan Fund, to be sponsored by the State Auxiliary was heartily endorsed as an excellent project.

This Auxiliary has a unique way of raising funds which you will hear about at our Annual Meeting to be held in Tampa.

And, may I bring to your attention, "Medicine in the News," timely topics from the American Medical Association, and the National Broadcasting Company, every Thursday, 4:30 p. m. (*E. S. T.*) Blue Network—coast to coast. This series of thirty weekly broadcasts which opened November 2, 1939, feature "Facts, drama, entertainment, music." These announcements are on blotters, which may be secured free by writing to the American Medical Association, Chicago, Illinois. Please give these talks publicity in your Auxiliaries. And, may I add, now after the Christmas rush is over is a good time to put on that Health Program in your Woman's Club.

Dr. Spencer Folsom and Dr. Gilbert Osincup were our guest speakers in a Health Program put on in Orlando at the Sorosis, which

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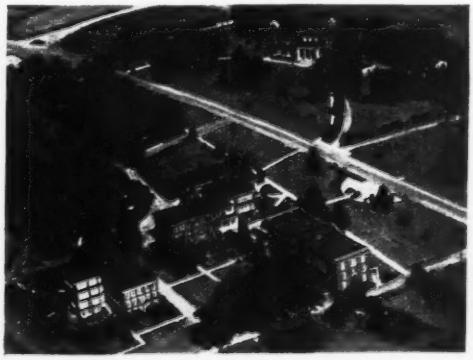

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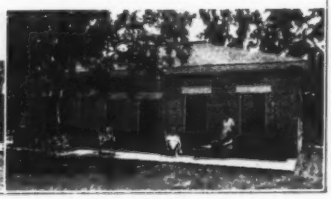

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Again, may this Holiday Season bring much happiness to you all.

Sincerely,
Carolyn F. Ingram

* * *

The Auxiliary to the Pinellas County Medical Society held its first meeting of the year on Tuesday, November 21 at 12:30 o'clock. This was a social meeting which was held at the Carleve Hotel with about thirty members present. The long luncheon table was decorated with bronze, yellow, and white chrysanthemums. The president, Mrs. C. O. Anderson, introduced the committee in charge of the luncheon and also special guests. She announced that no business would be taken up at the monthly meetings, but would be attended to at the regular meetings of the executive board. Mrs. Anderson reminded the group of the December meeting which was scheduled as a dinner dance with the husbands as guests. Following the luncheon, bridge was played by all those desiring to remain. The luncheon and afternoon seemed to be thoroughly enjoyed by all those present.

Mrs. O. N. Nelson.

* * *

The many friends of Mrs. Curtis Holt Sory of Ft. Lauderdale will be saddened to learn of her death on December 6, following a brief illness.

* * *

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This book will be a welcome reference book for all persons interested in securing authoritative information about foods, especially the processed and fabricated foods which are widely advertised. The accepted products are classified in various categories; fats and oils; fruit juices, including tomato juice; canned and dried fruit products; grain products; preparations used in the feeding of infants; meats; fish and sea foods; milk and milk products other than butter; foods for special dietetic purposes; sugars and syrups; vegetables and mushrooms; and unclassified and miscellaneous foods, including gelatine, iodized salt, coffee, tea, chocolate, cocoa, chocolate flavored beverage bases, flavoring extracts, dessert products, baking powder, cream of tartar, baking soda, cottonseed flour. There is a suitable subject index as well as an index of all the manufacturers and distributors of food products that stand accepted by the Council on Foods.

Accepted Foods is indispensable for the library of every physician concerned with foods and nutrition.

Cloth, price $2.00 postpaid. Pp. 512; Chicago: American Medical Association, 1939.

* * *

ROCKEFELLER FOUNDATION: INTERNATIONAL HEALTH DIVISION. ANNUAL REPORT, 1938. Each year the International Health Division of The Rockefeller Foundation publishes a separate account of its activities, intended for readers with a specialized interest in the field of public health. The program of this Division falls into three parts, the first of which concerns the control of specific diseases, such as yellow fever, influenza, malaria, and tuberculosis. The second deals with aid to departments of health, either central or local in character, engaged in health demonstrations or the initiation of permanent new lines of public health activity. Finally, the International Health Division is interested in public health education, in which support is given to selected schools and training centers, as well as to a program providing fellowships for postgraduate training in public health to men and women who, on completion of the fellowship, are assured of posts in the public health service of the country from which they come. New York: The Rockefeller Foundation, 1939.

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